Strategy Research Project

BEYOND JOINT MEDICAL TRAINING

BY

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The military services are responsible to recruit, train, equip and sustain their forces. For decades the Department of Defense (DOD) has received pressure to consolidate medical departments and therefore, DOD reciprocates that challenge to the uniformed services to create a single medical command. The Army, Navy and Air Force have always justified separate medical branches, by staunchly stating that war-time requirements demand unique medical skill sets for Soldiers, Seaman and Airmen. However, current combat environments have blurred the lines between distinctions of medical care. Medics and physicians from all military services work side by side to save lives and return warriors to duty. The Military Health System (MHS) is responsible for health care delivery in military hospitals and routinely use joint services health care providers. In 2005, Base Realignment and Closure (BRAC) established that, all military medical training sites for enlisted members will consolidate at Fort Sam Houston, Texas. Now is the perfect time to design, create, resource and mandate real JOINT medical training for our enlisted members. Military medical education can embrace process efficiencies to establish effective and realistic joint medical training.

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The military services are responsible to recruit, train, equip and sustain their forces. For decades the Department of Defense (DOD) has received pressure to consolidate medical departments and therefore, DOD reciprocates that challenge to the uniformed services to create a single medical command. The Army, Navy and Air Force have always justified separate medical branches, by staunchly stating that war-time requirements demand unique medical skill sets for Soldiers, Seamen and Airmen. However, current combat environments have blurred the lines between distinctions of medical care. Medics and physicians from all military services work side by side to save lives and return warriors to duty. The Military Health System (MHS) is responsible for health care delivery in military hospitals and routinely use joint services health care providers. In 2005, Base Realignment and Closure (BRAC) established that, all military medical training sites for enlisted members will consolidate at Fort Sam Houston, Texas. Now is the perfect time to design, create, resource and mandate real JOINT medical training for our enlisted members. Military medical education can embrace process efficiencies to establish effective and realistic joint medical training.

BEYOND JOINT MEDICAL TRAINING

There have been many efforts to align Department of Defense (DOD) military services toward joint efficiencies with the goal of enhancing the effectiveness of the force. Unfortunately few have fully embraced "Joint" service in a pure form. According to the 2006 Strategic Plan for Transforming DOD Training, Secretary of Defense (SecDef), Donald Rumsfeld stated, "We must transform not only the capabilities at our disposal, but also the way we think, the way we train, the way we exercise, and the way we fight."[1] The Strategic Plan for Transforming DOD Training (T2)[2] attempts to validate that joint medical training for military services is considered a requirement under this joint publication.

Regardless of past efforts to transform medical training for the military services, the Defense Base Realignment and Closure (BRAC) in 2005 triggered one of the largest engineering and partnership deals in military medical education history for enlisted Soldiers, Sailors, and Airmen[3]. Number 172 (Med10) in the BRAC recommendations for 2005 indentifies Medical structure in Chapter VIII.[4] The following wording can be found under the Medical Joint Cross Service Group recommendations.

> Realign Lackland Air Force Base, TX, by relocating the inpatient medical function of the 59th Medical Wing (Wilford Hall Medical Center) to the Brooke Army Medical Center, Fort Sam Houston, TX, establishing it as the San Antonio Regional Military Medical Center, and converting Wilford Hall Medical Center into an ambulatory care center. Realign Naval Air Station Great Lakes, IL, Sheppard Air Force Base, TX, Naval Medical Center Portsmouth, Naval Medical Center San Diego, CA, by relocating basic and specialty enlisted medical training to Fort Sam Houston, TX.[5]

This decision created the ultimate launch for a potential "Joint" Medical Educational and Training Campus (METC) for all military services. The Secretary of Defense stated that the primary rationale for this recommendation is to transform legacy

medical infrastructure into a modernized joint operational medicine platform.[6] Co-locating the medical enlisted training with related military clinical activities at Fort Sam Houston, TX provides synergistic opportunities to bring clinical insight into the training environment, real-time.[7] The commission believes that both the healthcare delivery and military medical training experiences will be exponentially enhanced.

The consolidation of medical training to FT Sam Houston, TX is taking place. Air Force and Navy medical training sites are closing and their training Centers are preparing to realign and relocate to Texas. However, the services have not yet reached joint medical training agreements for the METC. Regardless of the final outcome, this is the largest single BRAC move in history, and Fort Sam Houston is sinking into the center of earth under all the weight of new construction. Bases and schools will continue to close and medical training platforms will continue to relocate at the same pace as brand new construction at FT Sam Houston. Although the final results of the METC will not be realized until it officially opens in 2011, portions of training will be operational this year. Radiology will begin class in 2009.

A true test of joint medical training will ultimately be based on the “outcome” while noting that efficiency of joint training for medical service members can never be outweighed by the effectiveness of student training. According to a 2006 briefing by MG George Weightman, then the Commanding General of the Army Medical Department Center and School (AMEDD C&S), the desire was to develop a degree-building and degree granting educational institution that will provide life-long medical education for medical forces in DOD.[8] MG Weightman also identified that this could be the path to a future Unified Medical Education and Training Command.[9] The benefits of joint medial

training can be numerous. Military medical departments should consider a Joint Medical Training concept and beyond.

There have been many initiatives for joint activities. The Goldwater-Nichols Act (GNA) of 1986 was a monumental reformation of government structure to ensure the services incorporated lessons learned from the Vietnam era. The political shift was to take some functional operations out of the services and enforce joint operations for the future. In order to achieve this objective, the Chairman of the Joint Chiefs of Staff (CJCS) was appointed to develop Joint Doctrine.[10] However the organizational environment needed to change in order to achieve results. A single individual or agency was needed to have oversight and accountability for joint doctrine between the services. Therefore, the J-7 created a separate Joint Doctrine Division for developing joint doctrine.[11]

The implemented changes by the Goldwater-Nicholas act attempted to fix inter-service rivalries. Those changes were a leap in the right direction, but the U.S. military was still organized, funded and supported by lines of service command, which was vetted through their respective service chiefs.[12] Even now there are a lot of inter-service turf rivalries. In October 2002 Secretary Donald Rumsfeld, advanced the joint working oversight of combatant commands and ordered that the functional and regional commanders be referred to as “combatant commanders” when in a “unified” region.[13] In essence, he merged all the services in a region towards a single commander. Just as the Goldwater-Nicholas Act inspired jointness at the senior levels, a recent study by the Center for Strategic and International Studies (CSIS) suggests that DOD is capable of accomplishing even more joint endeavors.

The Beyond Goldwater-Nichols (BG-N): U.S. Government and Defense Reform for a New Strategic Era, Phase 2 Report, CSIS, July 2005 addresses a topic of "building operational capacity outside the DOD".[14] Language in BG-N recognizes that most operational capabilities rest entirely within the Military and therefore the creation of a new agency, the Office of the Coordinator for Reconstructions and Stabilization (S/CRS).[15] S/CRS is supposed to synchronize the efforts and goals in the National Security Strategy (NSS). Not without merit, but lacking in precedence, one of the recommended solutions in this report was to create and fully fund rapidly-deployable civilian capabilities to strengthen the US Agency for International Development (USAID).

A standardized training program for rapidly deployable civilian medics could potentially be accomplished by a civilian training campus similar to the METC, except for USAID personnel. This fits well with our vision of Joint interagency operational missions. The study team also encouraged DOD to embrace and establish professional military education (PME) that is relevant to today's challenges. The JCS Chairman's vision for PME is to develop a Joint Virtual University.[16] Again, the medical community is a prime candidate to lead joint training initiatives. Historically medical already has a natural tendency to share sciences among professionals.

The following guidelines are derived from the 2006 DOD Quadrennial Defense Review (QDR) Report, the DOD Strategic Planning Guidance, the aforementioned implications for training and education, and results of the 2005 T2 assessments.[17]

(1) Continue building the live, virtual, and constructive (LVC) integrated and distributed joint training environment for export on a global scale and replicated the operational environment to the greatest extent possible.

(2) Integrated joint and service training, whether virtual or constructive simulation, opposing force capabilities, and range instrumentation.[18]

This certainly serves as the impetus for DOD medical training to develop the world's premier medical and educational center with joint training platforms.

The goal of Joint Forces Command (JFCOM) is to understand and guide the service capabilities so that they can be ready to provide the required capability at the request of the combatant commander. JFCOM has formulated and executes the Joint Knowledge Development and Distribution Capability Strategy (KDDCS).[19] If senior leaders continue to embrace KDDCS, it will become a valuable tool in meeting the combatant commanders' requests. KDDCS has the potential to transform the way DOD develops future leader's decision making to employ joint operational forces with quick innovation against the Nation's adversaries.[20] When applied properly, KDDCS interfaces will expand enterprise knowledge making it an interoperable tool with all combatant commands.[21] The ultimate goal of military force is to support the needs of the commander and often success of the mission is dependent on applicable systems. Interoperability of our systems and the ability to capture, share and export data is critical to our decision making and success. A current example of an effective joint and interagency system is the Joint Medical Information Systems (JMIS).

JMIS is a prime display of service cooperation and willingness to cross cultural boundaries to effectively and efficiently reach desired results. JMIS is under the TRICARE Management Office (TMA). The joint or tri-service objective is for TMA to ensure single source access to write contract language for all vendors.[22] To expand this discussion, TRICARE is part of the Defense Healthcare Services (DHS). The medical

community at any level has common core tendencies that advocate well towards jointness. By nature, joint medical partnerships are excellent low risk endeavors with potential high yield payoff.

Military medical information sharing and joint medical solutions have been very successful over the years. The Joint Medical electronic Information Workstation (JMeWs) is a huge success story for medical electronic interface, regardless of what service you belong to. JMeWs displays close to real-time medical information and data from the front lines of battle (forward deployed units) to the desks at the Pentagon. The information is entered into the medical system of choice by each service. Each service uses their service specific data capturing workstation. Through a sequence of data exchange points, the system provides a joint medical view of; battlefield medical concerns, treatment encounters, and in Washington DC for all the service Surgeon Generals (SG) and their operations staff and clinical staff to analyze. It is amazing how medical information and treatment encounters can interface at the DOD and strategic level with transparency and visibility across service and interagency lines. Joint information sharing is critical to the overall success of our medical mission.

The importance of Joint medical training for enlisted medics is to optimize joint medical coordination and support for the operational medic in the joint environment. For this reason, DOD is expecting the services to embrace joint medical training for our medics. Deployed medical forces are critical in providing force health protection measures for our combat and non-combat missions. It is paramount that joint medical planning expertise is incorporated into the skill sets of our medical system management. Planning factors for “real world” medical mission execution can range from

administering and recording immunizations, to ordering medical supplies to evacuating patients and reporting patient treatment status. It is important to remember that a patient eligible for treatment by a US military healthcare provider can be in a wide array of categories.

A casualty on the battlefield that requires treatment by one of our medics might be a civilian, a military service member, a coalition partner, or even one of our known adversaries. In fact, medic and medic skills required to maintain the war fighters' Force Health Protection (FHP) posture and caring for the wounded are identical to all other health provider services. The operating environment will constantly change, but the medical mission will generally remain consistent with current joint doctrine.

Defense Medical Readiness Training Institute (DMRTI) improves the medical readiness training for military medical personnel and the coordination of readiness training efforts between military and civilian organizations. DMRTI is an example of an interagency goal toward one mission. It also reduces duplication of readiness training efforts across services and decreases readiness training costs.[23] The similar goal for the Service should be focused on producing a well qualified medical provider that can save lives under hostile or extreme conditions on the battlefield. It shouldn't matter what Service the medic belongs to, it should matter that the medic is proficient in their individual life saving skills and ability to perform those skills under pressure.

Joint Training is often used as a buzz word or a cliché to meet a check mark on a paper. In today's dynamic mission set for medics, Joint training must be real, it must be effective, and it should be efficient. The METC mission statement according to the Army and Air Force Service briefings and the Military Health Services (MHS) Conference in

2008 is: “We produce the world’s best military healthcare personnel to support the nation”. The vision stated at the TRICARE conference in 2007 echo’s the same mission and vision as “the Nation’s leader in Military medical education and training”.[24] The pertinent question is who has ownership of the METC mission and vision? Is it the individual services responsibility? Are the services merely agreeing to “training together” or should this be directed under law, and if so, enforced by whom?

Many of our senior leaders and even General Officers have recognized that there is a critical need to train our services in joint ventures. However, one of the largest areas of angst in joint missions is control and ownership. The real show stopper for jointness is command authority. The medical community of the military services could benefit from a joint medical command concept. The interoperability of medicine in combat, humanitarian assistance or nation building during stability operations could exponentially improve patient continuity of care. Eventually the patient is either returned to duty or provided a higher level of care at another MHS center. It is rational to consider that our future military service requirements could be sourced by a unified medical support service.

The battlefields of today are no longer service specific battles fought by single service campaigns to win the ultimate single type of war. We are integrated services that desperately rely on the interoperability of individual service members to fight side by side for the same goal. Medics save lives and deliver medical care far forward on the battlefield. They evacuate patients to more defined care and stabilize for follow on treatment, evacuation to a fixed facility or return to duty (RTD). Treatment is recorded

through electronic portals. We are able to achieve complex maneuver and coordination for continuity of care even at remote locations across the world.

Joint National Training Capability Strategy, addressed in the 2006 Strategic Plan for Transformation DOD Training openly supports the concept to enable warriors to train as they fight.[25] This is a very important concept to support the Homeland Defense mission. The added bonus of consolidating training is that no war, especially one fought on American soil, will be purely a single agency fight. Medical care will have contributions and demands from all agencies, to include the Public Health Service, private organizations and non-governmental agencies. The concept of a single unified medical training campus for the Military Services is transformational; it is all about saving lives. Working together is even better than separately.

When organizations share knowledge it can be very powerful. The sharing of best business practices, technology advancements and process improvements breads empowerment. A neat phenomenon happens when long standing institutions achieve active knowledge sharing agreements that is reciprocated across their organizations; as individual organizations and as a collective type of institutions they expediential become more powerful. The opportunity is ripe to include not only the military services, but other interagency and community partners to join the teaching-learning experience of medical excellence. Even in Iraq the interagency is operating alongside the services. The medical clinic in Baghdad was owned by the Embassy; however, it was the Army's 146 Multifunctional Medical Battalion (MMB) that staffed the medical clinic. Under their Standard Operation Procedures (SOP) and MNF-I guidelines, JMeWS was utilized to enter the patient (PT) medical diagnosis and treatment procedures, to include

evacuation or movement of the patients.[26] JMeWS provides a number of critical informational data elements, such as reports on medical trends and analyzes the overall status of theater health through medical surveillance with drill down capability to medical units and encounters.[27] JMeWs is a medical information tracking system that joins all our individual medical tracking into one system of record and shares medical intelligence with Global Combat Support System and Global Command and Control System.[28] The Department of State (DOS) physician entered patient information data into our Army computers to make the information seamless.

Globalization is no longer a word or a concept about the future. We currently live in a global society. Even changes in our 2006 National Security Strategy (NSS) reflect the impact of globalization as a concern to our security. Recently, during the presidential election campaigns Barack Obama and John McCain referred to our limited global resources as a national concern. President Obama implied that the current recession and energy crisis has brought America to a point where we can no longer stand for redundancy and wastefulness of our national treasure. The military services will need to put our inter-service rivalries behind us and explore where resources can be shared. Our U.S. health care and the systems that deliver health care to Americans' are among the best. However, we must examine how we can improve our processes.

One of the focuses areas of the 2008 presidential election was our U.S. health care and access to it. President Barack Obama believes we must redesign our health care system to reduce inefficiencies and waste to improve health care quality. [29] BRAC 2005 was placed into law way before this election year, but the writing is on the wall that the time is now to focus on collective change in our medical institutions. This can apply

to or be equated to military services specific training as well as our health care delivery systems.

The Army medic has a 68 Whiskey (W) designator and is the second largest military occupational skill (MOS) in the Army.[30] Known as the combat medic, it is only second to the infantry man combat Soldier skill set. The following serves as a benchmark of the capabilities of Fort Sam Houston in medical training. The projected resident students are 26,058 per year, equating to 255 courses and 87 multi-service training programs, to include students from 75 different allied countries[31]. There is calculated potential that the Coast Guard will participate in this training too. In total, this equates to over 9,000 students on the METC campus at any given time.[32] We need this many trained medical personnel collectively in our services to meet our current and future needs. FT Sam Houston will become the medical training Center of Knowledge for the military medical world and is ideal for joint training for our common medic skills as well as joint medical specialties.

A real world example of joint or interchangeable medical requirements is the Military Iraq Transition Team (MiTT) medic in Iraq. The basic medic is embedded with a team of Soldiers and Marines that are teaching combat skills to the Iraqi Armed Forces. The medic is not only teaching the Iraqis medical skills, they are also caring for each member or the US team as well as the coalition team members in support of the Iraqis. This MiTT medic may be and Air Force Medic or an Army Medic.

The medical protocol of the services on the battle field is the same. Military medical culture must take the time to expose medics to all service specific tasks and demand common protocols and standards in execution. Medics need to be taught in the

school house and practice service specific systems during their training phases, not when they are deployed in austere environments. Training needs to take place at a learning center of excellence during initial medical skills indoctrination. Medics indentified to assignments in the fixed medical treatment facilities (MTF) or Table of Distribution and Allowances (TDA) are even suitable for common medical skill set training. Currently the Services are consolidating their medical treatment facilities into TRI-SERVICE centers, such as in the National Capital Region. Many of our military service hospitals, especially in the National Capital Region (NCR), have been operating in the joint mode for some time now. BRAC will also force our hospitals at Andrews Air Force Base, the Army's Walter Reed in DC and the Bethesda Navy Medical Center to realign and create a single world class, jointly staffed medical center complex for care of our service members and their families in the NCR.[33]

The medical moves addressed in BRAC established the location of the METC, but they did not direct the service to provide Joint Training. It was only implied that joint training "would be nice" to conduct at the METC. The stated goals of the services, delivered in their General Officer level briefings outline the METC operating principles as follows: Consolidate enlisted training from the five Service Medical Learning Centers (listed in BRAC) with standardized course and common core curriculum that captures best practices and maintains CCAF accreditation.[34] The actual stated goal is "an integrated campus under a single "University" administration".[35]

This was also indentified in the 2005 BRAC, but is even more prominent in the forward, creative thinking that is going on in Washington in recent years. The Goldwater-Nichols Act of 1986 was very effective at reorganizing DOD reporting chain

of command changes that were required based on structure and process that remained after Vietnam and World War II[36] Recently, Beyond Goldwater-Nichols publication, recognizes that strategic for national security concerns, must not only take a stab at inter-service rivalry, but this team, for the Center for Strategic and International Studies, is absolutely dedicated to, and recommends that we must unify our efforts in Interagency operations[37]. These suggested efforts to effectively integrate our national security apparatus are recommendations to effectively secure our homeland.[38] Interagency coordination and exposure to service cultures is paramount to bridge the universal medical understanding to work side by side in the heat of a crisis and for the common good of advancing medicine and saving lives. The services can take a giant step forward and achieve that goal by training together in an orchestrated training environment at a DOD medical campus.

Combining training for the services can provide numerous benefits to the medical services. However, change still causes stress and resistance. This is a normal reaction for leaders and members of any organization, especially large institutions. The culture is very ingrained as the members and leaders grow over time and when confronted with change, they want to say “no”. Many scholars have studied organizational change in large institutions and have identified three broad sources for resistance; (1) the fear of change, (2) the failure to recognize the need for change in the organization and (3) permitting obstacles to block the vision and direction for the change.[39] However, there are ways to understand and approach resistances to change and overcome these common obstacles. John P. Kotter, is a well known author on leadership and change. Kotter identifies eight stages that managers and leader should follow, especially when

leading successful change for institutions. The following eight stages are listed; (1) establish a sense of urgency, (2) create a guiding coalition, (3) develop a vision and strategy, (4) communicate the changed vision, (5) empower broad based action, (6) generated short-terms wins, (7) consolidate gains and produce more change, and (8) anchor new approaches in the culture.[40] These are well known stages of effective and successful change occurring in organizations, especially large institutions. For DOD to take on medical jointness for the services all of these actions, or stages required attention.

The sense of urgency for joint training comes with the T2 Strategic Plan, and BRAC 2005. BRAC also set the stage for the guiding coalition and gave birth to a possible strategy and vision to start publicizing. Furthermore, numerous study groups had determined Joint training recommendations are critical to future operations. However a key enabler that is lacking in this suggested change, is an agreed upon end state, vision or goal for the medical enlisted training campus. Without the shared vision, or the consensus of a well defined vision, the communication network to inform the customers and shareholders cannot be launched. Therefore the lack of a shared vision and a party line or communication platform to enable change are limited. This is evident in where the services are in their current juncture for the creation of the mega training installation in San Antonio, TX. The lack of senior leadership on the governance of the campus has almost crippled the services to the point that they are merely co-locating their training platforms. Therefore, at this rate the services will continue to teach only their individual enlisted service members. In an essence DOD has created a medical training umbrella to house the services medical training, but not to train collectively.

Even so the METC will become a reality. As we move forward DOD needs to continue adapting and building the best practices from the services. The Army recently identified the need to align their medics training with the civilian National Registry for Emergency Medical Technician (EMT).[41] Because, EMT certification is a national standard it insures the same techniques and procedures are taught and the student must demonstrate proficiency in each task to be awarded the skill identification. The CDC is one of our nation's leading institutions and a trusted agency. They have established high standards to remain on the cutting edge. This means not standing still, but adapting to change and even forecasting the next change. [42] DOD should consider workshops and training exercises with the public health system to build capacity in a topic area. Medicine has many common goals and teaming together to reach excellence should be one of our aspirations. Currently, all the services have effective and efficient training programs in their various locations around the US, as identified earlier. Based on the METC, our strategic leaders, trainers and program developers need to review each service specific course curriculum with a scrupulous eye and open mind. The best of the best must be incorporated into the future Joint curriculum. For example, the Army has all of their medics train to the National Emergency Medical Treatment (NEMT) program standards and as an Army requirement to maintain that Military Occupational Skill (MOS), the medic must register with the NEMT and maintain current through a designated training program. The NEMT standard should be incorporated into the joint training curriculum. The Air Force has worked hard to gain an accreditation through the AF academy.[43] I propose that all the standard service practices of excellence should be

embraced, coordinated and emulated into one platinum standard training standard of excellence for the joint training campus.

The reasons for consolidating the enlisted medical training at FT Sam Houston are not purely ideological for the center of training excellence for there is significant research to support financial cost savings too. According to a Center for Naval Analysis (CAN) report, “Cost Implications of a Unified Medical Command” the results are very apparent that a cost savings is very evident in a unified command that includes a joint medical enlisted training center.[44] According to the Education and Training section of the analysis, millions of dollars can be saved. Currently the Services include training venues from the following:

- Army Medical Department Center and School
- Navy Medical Education and Training Command
- Air Force Aerospace Medicine Command, Air Force Medical Support Agency, Air Education and Training Command, and Air Force Reserve Command

The training for the medical services can become joint and according to the Doctrine for Health Services Support in Joint Operations, Joint Pub 4-02 we should strive to be so. Consolidating the medical training infrastructure shows a cost savings of 10.1 million annually. By providing a single point of all medical skill set training for each service, this would assist in standardized training for Homeland response missions and Deployments. The military could provides joint medical skill sets to enhance a world class center of excellence for teaching and research as well as reach back from the battle field or duty workstation to the center of medical knowledge. This type of learning

environment could establish a long-term joint career learning path for our medical service members, offering a wide variety of opportunities to serve. A platform like this could easily take advantage of technology advancements and scientific research.

The services medical department should become one unified medical service. By consolidating our medical resources we create an all encompassing platform of unique capabilities. The unified medical command could provide the required medical flexibility to the combatant commander for combat health support or during health care restoration of a nation. Our strength is our collective knowledge and unique medical specialties. We need to take advantage of our collective resources.

Many of our fixed military medical treatment facility (MTF) already operate in a joint platform. The Landsthul Regional Medical center (LRMC) in Germany is a prime example of joint medical care. However, LRMC didn't reach their medical capacity or capability quickly; it took dedication to mission and perseverance to excellence over a period of five to six years.

All of these examples have medics and health care providers of all services and even other nations working side by side to achieve a common goal. Stabilizing and treating service members is the universal mission of a medic. However the services usually have different systems, equipment, and even concepts of point of injury care to the evacuation process.

Training is the cornerstone for combined operations. The benefits to the mission are tremendous, especially if we are operating in a joint, interagency of multinational environment. All the following situations will require, at a minimum, a joint response from our medical community. We may be operating within the borders of the United

States reacting to a natural disaster, such as Hurricane Katrina, or a Humanitarian mission anywhere in the world, such as the tsunami. Even more critical is operating in a combat zone, such as Iraq or Afghanistan, and especially during a peacekeeping mission in Africa.

The slogan “train as you fight” is also true for a new bumper sticker, and that is “train as you treat”. The medics and medical technician in DOD operate in a joint environment. DOD must transition to medics as an integrated system and not a single minded section of one type of service. For real world missions and interoperability, we must teach air force medics to load a ground ambulance, Army medics to transfer a patient onto a ship for treatment or evacuation, and a Navy Corpsman to evacuate a casualty by loading a litter on a UH-60 MEDEVAC. Of course, we can’t teach every possible battle field scenario, but we must teach our medics the basic medical treatment and evacuation protocol across all services. The goal is to know the algorithms and react instinctively in combat, every minute counts.

The Combat medic is the first line of intervention for injured men and women on the battle field. Their decisions are often life or death responses. The forward deployed medic is also the key for prevention of Disease Non-Battle Injury (DNBI) for the support troops. In past wars and conflicts, DNBI has taken more lives than combat inflicted wounds. The medics’ core goal is to “Conserve the fighting strength”. Basic medical training skill sets and advanced specialty skills should be the same for al. The core values and goals are the same; therefore, the classroom training needs to be the same. The Department of Defense should establish one of the medical services as the executive agent for enlisted medical training. This executive agent should be

empowered to lead all aspects of medical oversight, including training, doctrine, and program budgeting. The executive agent for enlisted medical training should be granted the authority to review all service's current training doctrine and the American Medical Association training standards to establish the DOD joint medical training doctrine. At a minimum, the American Red Cross and National Emergency Technicians Medical standards needs to be incorporated into the DOD training program as standard practices and centers of excellence.

Additionally, the civilian training skills that may be required by the USAID capabilities under the State Department should be conducted at the Joint medical training center. A committee for oversight should be appointed to ensure all aspects of joint medical training for enlisted service members is fully implemented and the vision for superior medical training is conducted and on target for ongoing growing success as a center of excellence. The BRAC consolidation for medical training to FT Sam Houston, TX is a giant step in making joint medical training a reality, however as we often say the devil is in the details; it is the small steps by the services to make this a national accomplishment for the services to merge their training together.

The Joint Interagency Coordination Groups (JICG)[45] has the ownership of ensuring the process for joint relationship is on track. The vision of the JICG is to improve relationships and leverage technology to enable analysis, understanding, coordination, and execution of unified actions.[46] A unified action is a broad generic term that describes the wide scope of actions, (including the synchronization and/or integration of multinationals military operation with the activities of local, state, and

federal government agencies and intergovernmental and nongovernmental organizations) taking place within unified commands.[47]

Conclusion

In retrospect of the past two decades, I clearly see a concerted effort by DOD to make the services openly explore jointness. It may be called many things, such as; change, transformation, economy of force, cost savings, survival of the fit, best business practice or exactly the opposite, such as; expensive, stupid, kingdom building, and unachievable. Whatever the label is I believe jointness is the future of our services. The thought of becoming dependent on another agency or service to meet your mission is almost unimaginable. Interdependency is an uncomfortable concept, especially in the military. For many it means no longer being in control. Leaders by nature desire absolute control. However the future definitely has a large joint mission. Actually we operate in a joint environment for most of our missions now. So why not embrace the inevitable and lead the joint initiative. The medical services need to see and then build the joint medical future.

Senior military medical leaders need to make the necessary changes in our joint medical doctrine that supports our ability to support the warfighter. The warfighter, and the combat support force to the warfighter is joint, so therefore our medical force needs to be joint. Our goal is to sustain the fighting forces by using our DOD medical resources to achieve the mission in the air, or on the land or sea. This requires forward thinking of how we get there. The first step is to train in a joint combined mission to produce the best medical technicians possible under a single governance authority at a joint training facility.

The joint vision for the METC must begin with a solid campaign design. Even though the campus infrastructural changes for the METC are well under way, it is not too late. The doctrine to guide medical to joint training is key to achieving this goal. Time is of the essence and there is no substitute for good leadership coupled with excellent training. The joint training doctrine should maintain the integrity of the services while embracing interoperability and quality continuity of care. As I have already stated, the goal is providing effective medical care. I believe the services are already performing effective joint medical care and therefore, joint doctrine will provide the services the framework to also be efficient.

Joint medical doctrine for training is critical to forcing the decision makers to make the way ahead for the METC. The Service Surgeon Generals, the Joint Staff (medical) and the JFCOM Surgeon should make joint medical training doctrine one of the highest priorities. The funding for the METC facilities has been allocated for some time now. The METC construction is on schedule, however the allocation for instructors and the administration staff is still not decided. Without the proper personnel allocation and identified training venues (service specific or joint) for the professors and instructors the buildings will not be manned. It is a military service requirement to identify and contract required personnel. The senior leaders must act on this now. Personnel allocation and relocation of personnel requires a large lead time on the front end, especially when transforming and building a training team of excellence.

Transforming DOD medical training will work. However, to ensure success for the largest premiere medical training center in America and possibly in the world takes the dedication of leaders laying the foundations of success at the top. Tough decisions must

be made to make it the world's leading medical training center for the best medical services in war and in peacetime. I advocate that as a DOD force multiplier, we should teach fundamental combat medical skills at a joint college campus. Specialty training for the medics can also be collectively taught at the same campus. For example, combine the radiology training for all the services, along with pharmacy, nursing, and so on. Equipment at the school house will be an action that the medical logistic community will need to work out, but that is secondary to the joint operational and training doctrine. Equipment is always being replaced. Doctrine and training are enduring.

I propose that we reach beyond service protocols and not only adapt to the joint medical future, but that we create it. The reality is that the next "big event" has the possibility of a being a catastrophic medical mission, such as a pandemic or a severe natural disaster with huge medical impact. If the "big event" occurs, we will need to be prepared to cross all medical service lines of communication to maintain optimal continuity of care. This may involve our civilian medical work force too, and if it does we need to approach them with one common military voice. Our ongoing persistent conflict demands that our medical services work together. Our medical care mission is being executed around the world in a joint environment. Medical care is a common language in our communities and it should be even more common in our services. No one service member deserves better care or different care than another. The time is now to join our military medical services, at least in training, and lead our nation's medical training capabilities into the future. Joint medicine adds synergistic value and can be capitalized on with joint medical training.

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